King Philip Regional High School – Daily Symptom Severity Scale Form

Name: ____ Grade: ___________________ Page: _____ of _____

Date: _____/_____/_____ Time: _____:_____ AM / PM

Symptom	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Pressure in Head	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
Sensitivity to Noise	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6
Feeling Like "In A Fog"	0	1	2	3	4	5	6
Don't Feel Right	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Fatigue or Low Energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total Number of Symptoms ____ / 22
Symptoms Severity Score ____ / 132

If 100% Is Normal, What Percent of Normal Do You Feel? __________%

Why? ____

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Do Your Symptoms Get Worse with Physical Activity? Y N
Do Your Symptoms Get Worse with Mental Activity? Y N

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